

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12555

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12550

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston		c. LENGTH OF STAY IN lb 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph		First Calvin	Middle Betts	4. DATE OF DEATH September 3 1966	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1900	9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Dagsboro, Delaware	
13. FATHER'S NAME Artemus W. Betts		14. MOTHER'S MAIDEN NAME Elnora Green		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-20-2675		17. INFORMANT Mrs. Eva Betts, Preston, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY		INTERVAL BETWEEN ONSET AND DEATH 30 minute			
IMMEDIATE CAUSE (a) 4-201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank M. Anderson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank M. Anderson M.D.		Address (Street, city, town, or county) Federalsburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE THEREOF Sept. 6, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS Home Frampton Jr.	25a. REC'D BY REGISTRAR DATE SEP 6 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT.

12556

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12551

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 22 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Paul</i>	Middle <i>N</i>	Last <i>Biggers</i>	4. DATE OF DEATH <i>July 4, 1966</i>
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 31, 1921</i>	9. AGE (in years last birthday) 45 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dentist (D.D.S.)</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Kent Co. Md.</i>	
13. FATHER'S NAME John		14. MOTHER'S MAIDEN NAME Biggers Mary E.		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219 34 3117		17. INFORMANT John Biggers Address Rock Hall, Md. Father	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>9170</i>		1st, 2nd, 3rd degree burns complicated by asphyxia due to aspiration of soot material, DUE TO <i>asphyxia due to aspiration of soot material,</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>70xx4004474</i> DUE TO <i>barbiturate intake and carbon monoxide</i> (c) <i>poisoning</i>			
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Found dead in his bedroom</i>			
20c. TIME OF INJURY Month, Day, Year Hour p.m. 6:00 9 11 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
(State) Greensboro Caroline Md.		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John W. Rieckert</i>					
EXAMINER'S NAME (Type) <i>John W. Rieckert</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>E. New Market Rd.</i> 22. DATE SIGNED <i>9-12-66</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/14/66		23c. NAME OF CEMETERY OR CREMATORIUM Chester Cem.	
23d. LOCATION (City, town or county) (State) Chestertown Md.					
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE SEP 14 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

18291

272

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy may be necessary, please execute "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit to Boxes 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12557

12558

1. PLACE OF DEATH

b. COUNTY

CAROLINE
DENTON

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL)

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

b. COUNTY

MARYLAND CAROLINE

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

DENTON

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

JAMES First

MIDDLE

Last

DATE
OF
DEATH

Month SEPT.

Day 6

Year 1966

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

AUG 9, 1906

9. AGE (in years
last birthday)

60 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MERCHANT MARINE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

SALEM BLADES

14. MOTHER'S MAIDEN NAME

MARY ALTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes or no/unknow) (If yes, where & date of service)

YES WW II

16. SOCIAL SECURITY NO.

221-05-4383

17. INFORMANT

Mrs. Mildred Gross, 8 W 6th St Marcus

Address

HICK, PA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured Esophageal Varices

5/11
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO Laennec Cirrhosis

(b)

DUE TO

Chronic Alcoholism

(c)

INTERVAL BETWEEN
ONSET AND DEATH
minutes

2-4 yrs

7

MEDICAL CERTIFICATION

Gene Alized arteriosclerosis

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.
p.m.

19

Not White

at work at work

20d. INJURY OCCURRED

White

Not White

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE
Harold B. Plummer M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED
9/8/66

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

SPRING HILL

22d. LOCATION (CITY, TOWN, OR COUNTRY)

EASTON

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE SEP 13 1966

Charles Judge

3600

700-1000

1000-1500

1500-2000

2000-2500

2500-3000

3000-3500

3500-4000

4000-4500

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6500-7000

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12558			12558						
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro			c. LENGTH OF STAY IN 1b 1 year						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Collins Nursing Home			d. STREET ADDRESS Galestown						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First Mary	Middle Maria	Last Brady	4. DATE OF DEATH September 28 1966	Month September	Day 28	Year 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1907	9. AGE (In years last birthday) 59 yrs.	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS. Days 0	12. HOURS Hours 0	13. MIN. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Leland, North Carolina	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Christsburgh Potter			14. MOTHER'S MAIDEN NAME Mamie M. Holland						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.	17. INFORMANT	Address				
				Ellis M. Potter, Seaford, Del., R.F.D. #3					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome									
DUE TO (c) Post Encephalic Parkinson's Disease									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Decubitus ulcer of sacrum									
INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Seaford	(County) Dorchester Co.	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from Dec. 29 1964 to Sept. 28 1966 , that (I) (we) last saw the deceased alive on Sept. 28 1966 , and that death occurred at 9 P.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Charles H. Stoenesifer</i>									
22c. PHYSICIAN'S NAME (Type) Charles H. Stoenesifer, M.D.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	M.D. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/1/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 1, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Galestown Cemetery	23d. LOCATION (City, town or county) Galestown, Dorchester Co., Md.	(State) Md.			
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland			ADDRESS (from Frampton Jr.)	25a. REC'D BY REGISTRAR OCT 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15 (4) 15M 4-64									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		12554	
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg			c. LENGTH OF STAY IN 1D 5 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Willoughby Nursing Home						d. STREET ADDRESS Old Denton Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First Ruth	Middle Ware	Last Callender	4. DATE OF DEATH September 27 1966	Month September	Day 27	Year 1966						
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1902	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 63	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) New Jersey						12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Millard Ware						14. MOTHER'S MAIDEN NAME Elizabeth Ludlam									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 136-18-7410			17. INFORMANT Mrs. Erma C. Huff, Federalsburg, Md.			Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>												<i>Cardiac Failure</i> 2 days			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Hypertension Arterosclerotic Vascular Disease</i> 10 yrs															
(c) <i>Generalized arterosclerosis</i> ?															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>C.V.A. e hemiplegia left</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <i>Apr. 7, 1962</i> to <i>Sept 7, 1966</i> , that (I) (we) last saw the deceased alive on <i>Sept 7, 1966</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.												22b. DATE SIGNED 9-28-66			
22a. SIGNATURE <i>J.W. Frampton</i>												22b. DATE SIGNED 9-28-66			
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS Federalsburg, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 1, 1966			23c. NAME OF CEMETERY OR CREMATORIUM Seaview Cemetery			23d. LOCATION (City, town or county) Rockport, Maine (State)						
24. FUNERAL DIRECTOR <i>J. J. Frampton and Son, Federalsburg, Maryland</i>			ADDRESS <i>J. J. Frampton and Son, Federalsburg, Maryland</i>			25a. REC'D BY REGISTRAR SEP 30 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

CAROLINE

b. CITY OR TOWN. If out of corporate limits write RURAL and give nearest town)

FEDERALSBURG RURAL

d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital, give street address

RD#2 BOX 117

First Middle

3. NAME OF DECEASED
Type or print

LILLIE

MAY

COLLINS

5. SEX

6. COLOR OR RACE

FEMALE WHITE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

NOV. 14, 1888

10a. OCCUPATION Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

HOUSEWIFE

OWN HOME

11. PLACE OF DEATH City & State or foreign country

SUSSEX - DELAWARE

13. FATHER'S NAME

HUFF ORLANDO GORDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service]

NO

16. SOCIAL SECURITY NO. 17. INFORMANT

JOANNA HITCHENS

Address

18. CAUSE OF DEATH [Enter only one cause per line for a, b, and c.]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) My grandchild's -DUE TO
Conditions of any which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)
(c)

old falls - vascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia

19. WAS AUTOPSY PERFORMED?
YES NO

replenishes me with new resources

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of II in 18

20c. TIME OF INJURY Month, Day Year
Hour a.m. 20d. INJURY OCCURRED While at work Not While at work
p.m. p.m. 1920e. PLACE OF INJURY Home, farm
factory, street, office bldg., etc.)

City or town County, State

21. I certify that (I) (the hospital) attended the deceased from

952 ..., 19, to Sept. ..., 1966,

saw the deceased alive on 9/24

that death occurred at 11:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Catherine C Gray
cc. Gray m &

MD

ATTENDING PHYS

MED. DIRECTOR

STAFF PHYS

22b. DATE SIGNED

22c. PHYSICIAN'S NAME, TYPE

22d. ADDRESS

203 West 4th Street

Bridgewater, Del.

State,

23a. BURIAL, CREMATION REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

SEAFOUR, DELAWARE

State,

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REG STRAR 25b. REGISTRAR'S SIGNATURE

Raynor M. Watson SEAFOUR, DEL.

DATE

SEP 21 1966 Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										13968							
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Res dence before admission)		a. STATE		Maryland		b. COUNTY		Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Federalsburg - Rural		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		Federalsburg - Rural		e. IS RESIDENCE ON A FARM?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Richardson Road				d. STREET ADDRESS		Richardson Road									
3	NAME OF DECEASED (Type or print)	First James	Middle Ballard	Last Hubble	4	DATE OF DEATH September 23 1966	Month Day Year	5	SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1883	9. AGE (In years last birthday) 83 yrs.	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Smith County, Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13.	FATHER'S NAME Andrew J. Hubble			14. MOTHER'S MAIDEN NAME Luvica Cregger													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-44-6015		17. INFORMANT Mrs. Scottie M. Hubble, Federalsburg, Md.		Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a)				DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		hypocardial infarction								INTERVAL BETWEEN ONSET AND DEATH			
DUE TO (b)																	
DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 19. 66, PM 2351 ft		(County) 19. 66, PM 2351 ft		(State) 19. 66, PM 2351 ft							
21. I certify that (I) (this hospital) attended the deceased from <u>6 Sept</u> , 1966, PM 2351 ft, 1966, that (I) (we) last saw the deceased alive on <u>23 Sept</u> 1966, and that death occurred at <u>4:40</u> PM, from the causes and on the date stated above.														22b. DATE SIGNED 5 Oct 66			
22a. SIGNATURE Thurston Harrison				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) THURSTON HARRISON		22d. ADDRESS Carter Maryland															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery		23d. LOCATION (City, town or county) Federalsburg, Maryland		(State)									
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.		ADDRESS Home, Frampton				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE									
						DATE OCT 10 1966											



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		12556		
1. PLACE OF DEATH B. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE Maryland		b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Greensboro		c. LENGTH OF STAY IN 16 72 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Greensboro						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		None		d. STREET ADDRESS		None		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month	Day	Year					
John		Lawrence	Kibler			○	27	19	66					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	FUNDER 1 YEAR	FUNDER 24 HRS.							
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	3-6-1804	75 yrs.	Months	Days	Hours	Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Retired Farmer						Maryland			USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME												
Louis Kibler		Unknown												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address								
		218-14-4009		Charles Kibler Goldsboro, Md.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
This is a terminal disease. No other causes.														
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
19														
21. I certify that (I) (this hospital) attended the deceased from 19 to 27, 1966, that (I) (we) last saw the deceased alive on 27, 1966, and that death occurred at M, from the causes and on the date stated above.														
22a. SIGNATURE														
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED						
Charles H. Hausey		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		12-22-66						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)						
Private		2-7-66		Holy Cross		Greensboro		Maryland						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Charles Hausey		Greensboro, Md.												
VR A15 (4) 20M 1/65		DATE												



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12557

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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PLACE OF DEATH a COUNTY CAROLINAS		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b STATE MD		b COUNTY DENTON	
b CITY OR TOWN (If outside corporate limits, w/ re RURAL and give nearest town) DENTON, MD		c LENGTH OF STAY IN 1b life		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) DENTON			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First WILLIAM	Middle KENNETH	Last KENNETH	4 DATE OF DEATH JULY 19 1966	Month JULY	Day 1	Year 1966
5. SEX M	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH DEC 14 1919	9 AGE (In years last birthday) 46 yrs	F UNDER 1 YEAR Months 11	F UNDER 24 HRS Days 14
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) 1914 - 1966		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME GEORGE KENNETH		14 MOTHER'S MAIDEN NAME PEARL STAUTUM		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16 SOCIAL SECURITY NO.	
17 INFORMANT Mrs. G. W. M. KOENIG, DENTON, MD		Address		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
19 WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 1b)	
20c TIME OF DEATH Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1130 - 8291 66		20f (City or town) (County) (State)	
21. I certify that (I) (This physician) attended the deceased from 11/30/1966 to 8/29/66 , that (I) (we) last saw the deceased alive on 7/29/1966 and that death occurred at 8:35 AM , from causes and on the date stated above		22a SIGNATURE W. A. Anderson		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) W. A. ANDERSON		22d ADDRESS Deacon, Md.		23a LOCATION (City or Town) DENTON		(County) (State)	
23b BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL DENTON		23d. LOCATION (City or Town) DENTON		(County) (State)	
24 FUNERAL DIRECTOR M. M. Deacon		ADDRESS DENTON		25a RECEIVED BY REGISTRAR DATE SEP 6 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Denton		c. LENGTH OF STAY IN lb 40 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hospital 217 S. 3rd St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Lawrence	Last Laranore
4. DATE OF DEATH Month Day Year Sept. 26 1966	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9-7-1890	9. AGE (in years at birthday) 75	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William H. Laranore	14. MOTHER'S MAIDEN NAME Anna Vicory		
15. WAS DEC EASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. 	17. INFORMANT Dr. William Laranore, Jr.	Address 1100 S. 3rd Street, Baltimore, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artherosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 		
20c. TIME OF INJURY Month, Day, Year Hour a.m. September 26, 1966 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State) Baltimore, Maryland
21. I certify that (I) (this hospital) attended the deceased from 4-1 , 19 66 , to 9-23 , 19 66 , that (I) (we) last saw the deceased alive on 9-23 , 19 66 , and that death occurred at C , M, from the causes and on the date stated above.			
22a. SIGNATURE William Laranore, Jr.	22b. DATE SIGNED 9-27-1966		
22c. PHYSICIAN'S NAME (Type) 	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 9-26-66	23c. NAME OF CEMETERY OR CREMATORIAL Greensboro	23d. LOCATION (City, town or county) (State) Greensboro, Maryland
24. FUNERAL DIRECTOR J. E. Bowles, Greensboro, Md.	ADDRESS 	25a. REC'D BY REGISTRAR Sep. 27, 1966	25b. REGISTRAR'S SIGNATURE



1
FOR STATE
HEALTH DEPT.

M

is necessary,
please execute.
Indicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the
Chief Medical Examiner's Office along with form PM3; Page 5 may be retained for your files
and forwarded to the Chief Medical Examiner's Office along with form PM3; Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health
or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12560

1. PLACE OF DEATH
a. COUNTY

CAROLINE
RURAL DENTON

MARYLAND

2. USUAL RESIDENCE Where deceased lived, if institution Residence before admission

STATE

MARYLAND

b. COUNTY

CAROLINE

b. CITY OR TOWN If outside corporate limits
W.R. RURAL Ind give nearest town

c. LENGTH OF STAY IN lb
CITY OR TOWN If outside corporate limits w.R. RURAL d.g.v. ne rest w.r.

d. NAME OF HOSPITAL OR INSTITUTION If not in hospital give street address

HILLSBORG

e. S. RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
Type of birth

First MIDDLE Last
BLANCHE EVELYN MCROSSE

Date
of
death

Month

Day

Year

SEPT

22

1966

4. SEX

6. COLOR OR RACE

F ; W

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

OCT 8, 1903

19. AGE
last birthday
yrs.

UNDER 1 YEAR
MONTHS
WEEKS
MOS.

WIDOWED DIVORCED

10. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE State & foreign

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

WILLARD RUSSELL

14. MOTHER'S MAIDEN NAME

EUGENIA FLEMING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or dates of service)

No

Address

MRS BETTY HEWITT, WORTON, MD

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause of death or list up to 5 causes]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

(b)

Multiple fractures, cervical and thoracic vertebrae, rib fractures, etc.

DUE TO

(c)

extensive internal injuries

immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Eg. Nature of injury in Part I or Part II, etc. from 18)

20c. TIME OF INJURY N.D. 20d. INJURY OCCURRED 20e. PLACE OF INJURY Home, office, factory, off office, etc.

Hour a.m.

White

Hour p.m.

N.W. s

at work

at work

etc.

etc.

21. I certify that I took charge of the remains described above, had an Autopsy Inspection Inquiry and in my opinion

death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or country)

DATE SIGNED

9/2. 65

22a. BURIAL, CREMATION, REMOVAL Spec'y

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

24a. REC'D BY REG STRAR

24b. REGISTRAR'S SIGNATURE

VIRGIL MCROSSE

DENTON, MD.

DATE OCT 2, 1966

00



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12561

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

136		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND						23d. LOCATION (City, town or county) (State)		
1. PLACE OF DEATH a. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Ridgely		c. LENGTH OF STAY IN MD 52 Yrs.		b. COUNTY		Caroline		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		None		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		None		
3. NAME OF DECEASED (Type or print)		First James	Middle Fannest	Last Nichols	4. DATE OF DEATH	Month 9	Day 24	Year 1966		
5. SEX		6. COLOR OR RACE Male Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1914	9. AGE (in years last birthday) 52 yrs.	10. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME James E. Nichols	14. MOTHER'S MAIDEN NAME Lottie Bedford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-32-0811		17. INFORMANT Laura Nichols Ridgely, Maryland		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Underlying fibrillation</i> DUE TO (b) <i>Congestive Heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>High fever + heart attack (not fibrillation)</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/15/66 to 7/15/66, that (I) (we) last saw the deceased alive on 7/15/66, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 1611 118 316 29						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-27-66		23c. NAME OF CEMETERY OR CREMATORIUM Sandtown		23d. LOCATION (City, town or county) (State) Hillsboro, Maryland				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DATE 8/2/66				



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12562

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and/or any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Caroline MARYLAND		Maryland b. COUNTY Caroline	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Federalsburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Nichols Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Laura	Middle Emily	Last Patten
4. DATE OF DEATH	Month September	Day 11	Year 1966
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVDRCD <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1883
Female	White		9. AGE (in years) IF UNDER 1 YEAR Last birthday 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Caroline County, Maryland USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Todd		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Hilda Passwater, Federalsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Due To (b) Due To (c)		Cardiac Failure 2 wks -	
		Coronary arteriosclerosis 5 yrs	
		Atherosclerosis - generally 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <input checked="" type="checkbox"/> (his hospital) attended the deceased from Jan. 20, 1960, to 1966, that (I) (we) last saw the deceased alive on Apr. 7 1966 and that death occurred at 8 P.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>H. R. Trapnell</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) H.R. Trapnell, M.D.		22d. ADDRESS 128 Bloomingdale Ave, Federalsburg, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-14-1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Wesley Church Cemetery		23d. LOCATION (City, town or county) Burrsville, Md. (State)	
24. FUNERAL DIRECTOR <i>Jesse Frampton Jr.</i>		25a. REC'D BY REGISTRAR Frampton Funeral Home, Federalsburg, Md.	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

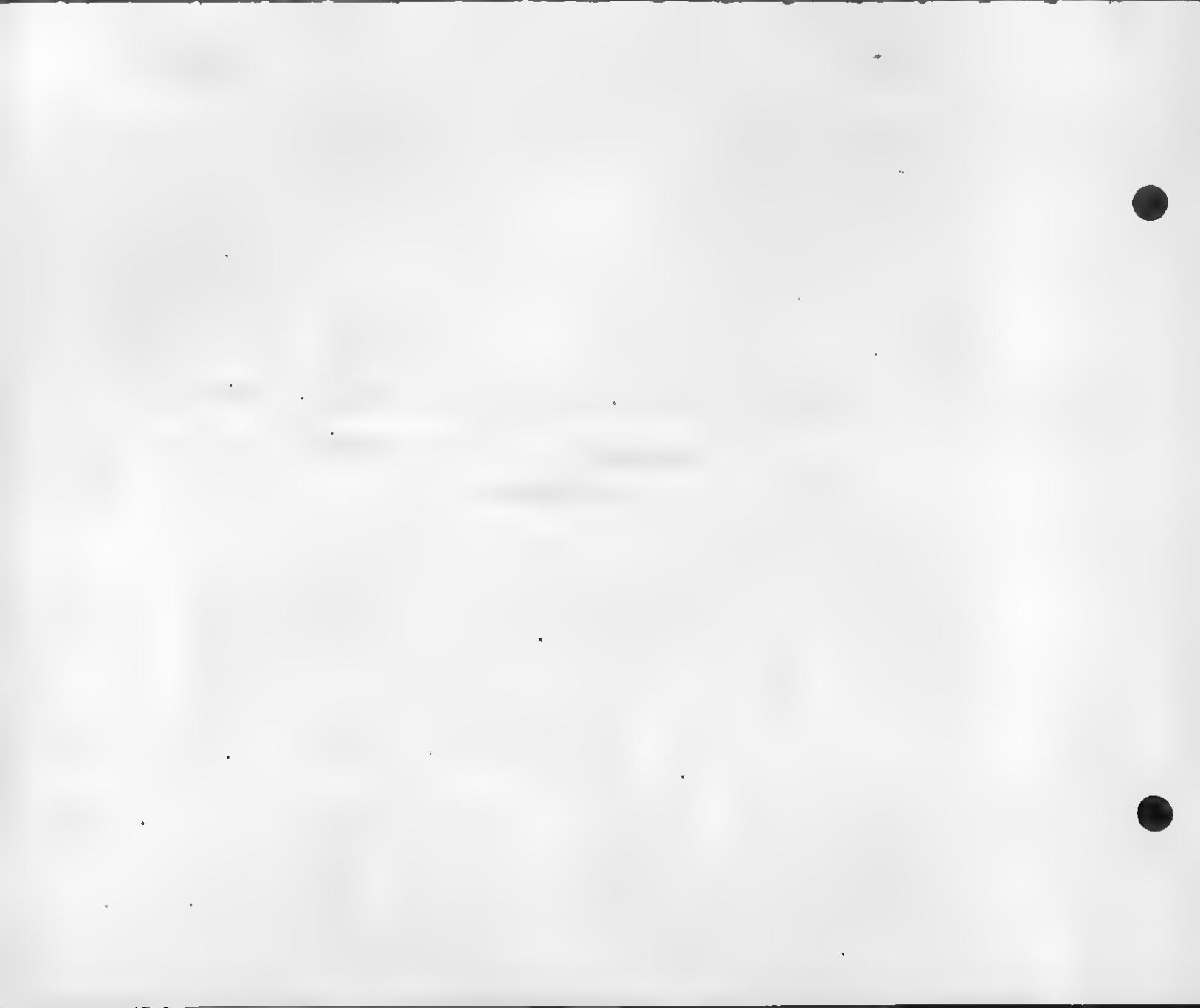
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12563

1. PLACE OF DEATH a. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
						a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Greensboro		1 week		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Preston	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Collins Nursing Home				d. STREET ADDRESS		None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Female	Gladys		Thornton	Sent.	21	19	66		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
	White			1-30-1901	yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		None		Virginia		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No Record Clayton C. Russell		Tone Russell Turlington		No		Unknown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH	
		DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO		(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <u>Sent. 20, 1966</u> to <u>+ 21, 1966</u> , that (I) (we) last saw the deceased alive on <u>+ 21, 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE		<u>Clayton C. Russell</u>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		m.d. - H. S. Collins M.D.		22d. ADDRESS				<u>Sent. 22, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)	
Burial		9-25-66		Mechanic		Chincoteague, Va.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		<u>J. E. Bouland Greensboro, N.C.</u>							
DATE		SEP 23 1966							





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

12570

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12565

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - FEDERALSBURG		c. LENGTH OF STAY IN TB LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FEDERALSBURG, RFD		e. STREET ADDRESS THREE BRIDGES Road	
3. NAME OF DECEASED (Type or print) SARAH		First ELIZABETH	Middle TURNER
4. DATE OF DEATH SEPT. 22 1966	Month Sept.	Doy 22	Year 1966
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH OCT. 25, 1925	9. AGE (In years last birthday) 40	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) CAROLINE COUNTY, MARYLAND	
12. CITIZEN OF WHAT COUNTRY USA	13. FATHER'S NAME SAMUEL R. BRUMMELL		
14. MOTHER'S MAIDEN NAME ELLA G. TILGHMAN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		
16. SOCIAL SECURITY NO. 213-16-8620	17. INFORMANT MRS. ANNIE R. WOODS, FEDERALSBURG, MD RFD	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Right Internal Carotid Artery			
DUE TO (b) Bullet shot thru the neck			
DUE TO (c) Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bullet removed	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 9/22 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Her home
20f. (City or town) FEDERALSBURG		(County) CAROLINE	
(State) MARYLAND			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Harold B. Plummer M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Harold B. Plummer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 26, 1966	23c. NAME OF CEMETERY OR CREMATORIAL FEDERAL HILL
23d. LOCATION (City or Town) FEDERALSBURG, CAROLINE, MARYLAND		(County) (State)	
24. FUNERAL DIRECTOR J.J. FRAMPTON & SON		ADDRESS FEDERALSBURG, MARYLAND	25a. REC'D BY REGISTRAR DATE SEP 30 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page _____ be retained by the hospital or attending physician.

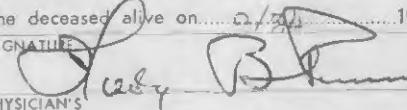
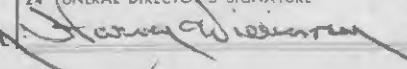
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12571

12566

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston, Md. RFD.		b. COUNTY Caroline	
c. LENGTH OF STAY IN lb 13 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Smithston) Preston, Md. RFD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hazel Louise Willoughby		First	Middle
4. DATE OF DEATH Sept. 30, 1966 19		Last	Month Day Year
5. SEX fem.		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH July 13, 1920		9. AGE (in years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY clerical	10c. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.
11. MOTHER'S MAIDEN NAME Elizabeth L. Ford		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold S. Taylor		14. INFORMANT Wm. J. Willoughby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) no		16. SOCIAL SECURITY NO. 222-10-5415	17. ADDRESS Preston, Md. RFD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Gacinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Breast left DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 mos	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) Preston, Maryland		(County) M.D.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 11/2/53 , 19, to 9/30/66 , 19, that (I) (we) last saw the deceased alive on 12/24/65 , 19, and that death occurred 10/1/66 from the causes and on the date stated above.		22b. DATE SIGNED 10/3/66	
22e. SIGNATURE 		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Harold P. Plummer M.D.		22d. ADDRESS Preston, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-3-66	23d. LOCATION (City, town or county) Linchester, Md.
24. FUNERAL DIRECTOR'S SIGNATURE 		Jr. Order Cemetery ADDRESS Federalsburg, Md.	25a. REC'D BY REGISTRAR Charles Judge
VR A15 (4) 15M 7/61		25b. REGISTRAR'S SIGNATURE OCT 5 1966	

